HOUSE . . . . . No. 2698

By Mr. Koutoujian of Waltham, petition of Peter J. Koutoujian and others relative to access to physician care and establishing a physicians advisory council. Public Health.

The Commonwealth of Massachusetts

PETITION OF:

Peter J. Koutoujian
Rachel Kaprielian
John W. Scibak

In the Year Two Thousand and Five.

AN ACT TO IMPROVE TIMELY PAYMENTS AND QUALITY, DELIVERY AND ACCESS TO PHYSICIAN CARE IN THE COMMONWEALTH.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. There shall be established a statewide physicians advisory council to annually advise the Governor and the General Court on the state of physician practice in the commonwealth and its impact on patient care. The council shall consist of the following twelve members: the secretary of the executive office of health and human services, who shall serve as chairman; the commissioner of the division of health care finance and policy; the commissioner of the division of medical assistance; and nine members to be appointed by the secretary and approved by the governor including the president of the Massachusetts Medical Society or his designee; the Governor of the Massachusetts Chapter of the American College of Physicians or his designee; the executive director of Health Care for All or his designee; the executive director of the Massachusetts League of Community Health Centers or his designee; a physician licensed under chapter 112 of the General Laws, and serving as the president of a health care system physician's organization or his designee; and four licensed physicians to be appointed by the governor who shall have experience caring for patients of programs administered by

the division of medical assistance, one of whom shall be a pediatrician, one of whom shall have substantial experience providing mental health care, and two of whom shall represent a cross-section of licensed physicians in the Commonwealth in terms of academic and community settings, geography and specialty, including primary care physicians. All appointed or elected members shall serve for terms of three years without compensation, except that four of the initial appointees shall be appointed to terms of two years each. The physicians advisory council shall adopt its own rules for conducting business, but shall meet at least quarterly. The secretary may provide staffing and other support as may reasonably be needed by the council, and the council may consult with such public or private persons and organizations as it deems necessary or appropriate, including the commissioner of the department of mental health, the commissioner of the department of mental retardation, the commissioner of the department of public health, the commissioner of the division of insurance, and the executive director of the group insurance commission. The statewide physicians advisory council shall:

(1) Examine and evaluate the state of physician practice in the Commonwealth and the impact on patient care;

(2) Gather and evaluate such payment, cost and quality data as the council deems reasonable and appropriate in order to monitor the cost, quality and effectiveness of health care services provided by physicians in conjunction with programs administered by the division of medical assistance and the group insurance commission. The data shall include, but not be limited to, physician reimbursement rates and fee schedules from the division of medical assistance and the group insurance commission for previous and current fiscal years. The council shall evaluate the adequacy of adjustments, if any, in such rates and fee schedules, as compared with inflation and other factors including prevailing fees and practice costs, and shall make annual recommendations regarding the adequacy of such rates and fee schedules and recommended changes in such rates and fee schedules, including annual inflation adjustments, in its report filed pursuant to paragraph (10);

(3) Gather and evaluate data on costs of delivering care as compared to payments to physicians providing health care services to patients of programs administered by the division of medical

assistance, and conduct a comparative analysis of physician revenues as compared to costs in other states and in the Medicare program, with such analysis adjusted for variations in wages, cost-of-living and other statistically significant factors;

(4) Survey the free care provided by physicians to uninsured and underinsured patients within the commonwealth;

(5) Gather and evaluate data and information on factors affecting the recruitment and retention of physicians in the commonwealth and the impact of such factors on patient care;

(6) Determine the availability of primary care and specialty care physician services statewide to patients enrolled in programs administered by the division of medical assistance;

(7) Review and evaluate the timeliness of payment to physician practices by public and private payors, and identify potential reforms to the administration of claims payment processes;

(8) Identify and recommend demonstration or pilot projects that test innovative ways to manage patient care for patients in programs administered by the division of medical assistance and the group insurance commission. Such projects shall be designed to improve the delivery and quality of patient care while lowering overall patient care costs and improving efficiency, and may include, but not be limited to cardiovascular disease management, catastrophic case care coordination, and improved pharmacy management. Recommendation for permanent implementation of such projects shall be included in the council's annual report, required by paragraph (10), and the council shall consult with physicians statewide in identifying such projects;

(9) Examine such other issues as the council determines necessary in order to evaluate the state of physician practice in the commonwealth and the impact on patient care; and

(10) Report annually to the governor and the general court on the second Monday of January. The report shall include, but not be limited to, a report of the council's work and activities for the previous year, including any findings and recommendations, which may include proposed administrative, regulatory, legislative or executive action, and shall include an estimate of the aggregate costs of such recommendations, if any. The council may supplement such reports from time to time.

SECTION 2. Notwithstanding any provision of general or special law to the contrary, and notwithstanding any regulations of the division of health care finance and policy or the division of medical assistance to the contrary, effective July 1, 2005, the fees payable under programs administered by the division of medical assistance for physician services shall be subject to the following:

(a) For each fiscal year, the schedule of maximum fees in effect at the end of the immediately preceding fiscal year shall be subject to an upward inflation adjustment as determined by the commissioner of medical assistance after consideration of the recommendations for such adjustment by the statewide physicians advisory council. The adjustment shall be at least equal to any upward adjustment in the United States consumer price index for physician services.

(b) For the fiscal years beginning on July 1, 2005, July 1, 2006 and July 1, 2007, each of the fees contained on the schedule of maximum fees in effect at the end of the immediately preceding fiscal year shall, in addition to the adjustment or adjustments provided for in subsection (a) above, be further adjusted upward by an amount equal to ten per cent of such fees. Notwithstanding the foregoing, adjustments under this subsection shall continue until such time as such fees are at least equal to physician fees under Medicare.

(c) Pursuant to regulations to be promulgated by the division of medical assistance by January 1, 2006, the division of medical assistance shall pay for, or assure that all of its contractors responsible for paying for physician services shall pay for, all office procedures appropriately provided by a physician practice during a single office visit to a person eligible to receive healthcare services under programs administered by the division of medical assistance.

SECTION 3. Section 1 of chapter 111 of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting at the end of the definition of "Medical peer review committee" or "committee" the following sentence:— "Medical peer review committee" or "committee" shall also include a committee serving the functions described in the previous sentence on behalf of a network contracting entity, provided that the governing body

of such entity shall have established such committee and charged it with performing the functions described in the preceding sentence.

SECTION 4. Said section 1 of chapter 111, as so appearing, is hereby further amended by inserting after the definition of "Medical peer review committee" or "committee" the following definition:—

"Network contracting entity", an entity that negotiates and enters into, on behalf of a network of providers that includes but is not limited to hospitals and physicians, contracts with health maintenance organizations organized under chapter 176G and that directly or indirectly receives payments from such an organization to be distributed in whole or in part to providers in its network, provided that the governing body of such entity shall include substantial provider representation.

SECTION 5. Subsection (b) of section 205 of chapter 111 of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by adding the following sentence:—

This section shall also apply to information and records of the types described in the first sentence of this subsection that is developed in conjunction with risk management and quality assurance programs established by a network contracting entity, as defined in section one.

SECTION 6. Section 12 of chapter 118E of the General Laws, as most recently amended by section 29 of chapter 140 of the Acts of 2003, is hereby amended by inserting after the seventh paragraph the following three paragraphs:—

The division shall, within 45 days of receiving a completed claim for reimbursement, or within 15 days if such claim is received electronically, from a provider of medical services that participates in a medical assistance program established pursuant to this chapter, (i) make payment for the services provided by such provider that are services covered under such medical assistance program and for which the claim is made, or (ii) notify such provider in writing of the reason or reasons for non-payment, or (iii) notify such provider in writing, based on the criteria estab-

lished pursuant to this paragraph, of what additional information or documentation is necessary to establish such provider's entitlement to such reimbursement. If the division fails to comply with the provisions of this paragraph for any such completed claim for reimbursement, the division shall pay, in addition to any reimbursement for medical services to which such provider of medical services is entitled, interest on the amount unpaid, which shall accrue beginning 45 days after the division's receipt of the completed claim for reimbursement, or beginning 15 days after the division's receipt of a completed claim for reimbursement if such claim is submitted electronically, at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim that the division is investigating because of fraud.

The division shall provide written guidelines to providers of medical services that participate in a medical assistance program established pursuant to this chapter setting forth a statement of its policies and procedures that is complete, detailed and specific with regard to what such providers must include in claims for reimbursement in order to qualify as a completed claim for reimbursement payment for which any such provider is entitled. Such guidelines shall identify all of the data and documentation that is to accompany each claim for reimbursement and shall identify all utilization review and other screening policies and procedures employed by the division in reviewing such claims submitted by a provider of medical services.

The division shall implement electronic claims processing systems that comply with the requirements of the federal health insurance portability and accountability act by no later than October 1, 2005, and shall process all claims by licensed hospitals and licensed physicians electronically by no later than July 1, 2006 and all claims from other providers of medical services as soon thereafter as is feasible. The division shall promptly notify providers in writing of the division's receipt of a claim or additional information or documentation required under this section, if such claim or information or documentation is not received electronically.

SECTION 7. Said section 12 of said chapter 118E of the General Laws, as so appearing, is hereby amended by adding at the end thereof the following subsection:

(a) In this subsection, "retroactive denial of a previously paid claim" means any attempt by the division to retroactively collect payments already made to a provider of health care services with respect to a claim by requiring repayment of such payments, reducing other payments currently owed to the provider, withholding or setting off against future payments, or reducing or affecting the future claim payments to the provider in any other manner. The division shall not impose on any provider of health care services any retroactive denial of a previously paid claim or any part thereof unless: (1) the division has provided the reason for the retroactive denial in writing to the provider; and (2) the time which has elapsed since the date of payment of the challenged claim does not exceed 12 months. The retroactive denial of a previously paid claim may be permitted beyond 12 months from the date of payment only if: (i) the claim was submitted fraudulently; (ii) the claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim; (iii) the health care services identified in the claim were not delivered by the provider; (iv) the claim payment is the subject of adjustment with another insurer, administrator, or payor; or (vi) the claim payment is the subject of legal action. The division shall notify a provider of health care services at least 15 days in advance of the imposition of any retroactive denials of previously paid claims. The provider shall have six months from the date of notification under this paragraph to determine whether the insured as other appropriate insurance, which was in effect of the date of service. Notwithstanding the contractual terms between the division and the provider, the division shall allow for the submission of a claim that was previously denied by another company due to the insured's transfer or termination of coverage.

SECTION 8. Section 24B of chapter 175 of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by adding the following three paragraphs:—

(a) Companies subject to the provisions of this section shall provide in writing to all providers of health care services which or

who have been regularly paid for services to policyholders or subscribers the following:

(1) a statement of each such company's policies and procedures that is complete, detailed and specific with regard to what must be included to qualify a claim for reimbursement as a completed claim for reimbursement for which such providers of health care services are entitled to payment, which statement shall identify all of the data and documentation that is to accompany each such claim and shall identify all utilization review and other screening policies and procedures employed by each such company in reviewing claims for reimbursement;

(2) prompt, written acknowledgement to providers of receipt of claims or additional documentation or information if such claims or documentation or information are not received electronically;

(3) all policies and procedures relating to utilization review and quality improvement, including policies regarding medical necessity, appropriateness of care, and location for the provision of care,

(4) credentialing standards,

(5) data reporting requirements,

(6) policies on confidentiality,

(7) guidelines or criteria for the furnishing of specific services,

(8) policies and procedures related to such other areas of contract administration as the commissioner may from time to time identify. Further, each such company shall notify all such providers in writing of any material change in any of the policies, procedures, standards, requirements, guidelines or criteria encompassed by this subsection, at least 60 days prior to the effective date of any such change. Each company subject to the provisions of this section shall administer its completed claim for reimbursement policies in a consistent manner for all providers of health care services which or who have been regularly paid for services to policyholders or subscribers, with the intent to assure efficient and timely processing of claims for reimbursement in a way that minimizes the number of claims re-submissions required of such providers, and which does not impose unreasonable documentation burden upon providers beyond what is necessary to document that the services were provided appropriately. Upon the request of a provider of health care services to any such company, such com-

pany shall make a good faith effort to cooperate with such provider to implement electronic claims processing for at least ninety per cent of such provider's claims.

Any contract between a company subject to the provisions of this section and a hospital or physician regularly paid for services to policyholders or subscribers shall preclude such company, either on its own behalf or on behalf of a self insured plan, including the group insurance commission, from unilaterally modifying significant economic terms of any such contract, including the fees paid to such hospitals or physicians, without providing the affected hospital or physician a reasonable opportunity for negotiation over the modifications and an opportunity to terminate the contract.

(b) In this subsection, "retroactive denial of a previously paid claim" means any attempt by a company subject to the provisions of this section to retroactively collect payments already made to a provider of health care services with respect to a claim by requiring repayment of such payments, reducing other payments currently owed to the provider, withholding or setting off against future payments, or reducing or affecting the future claim payments to the provider in any other manner. No such company shall impose on any provider of health care services any retroactive denial of a previously paid claim or any part thereof unless: (1) the company has provided the reason for the retroactive denial in writing to the provider; and (2) the time which has elapsed since the date of payment of the challenged claim does not exceed 12 months. The retroactive denial of a previously paid claim may be permitted beyond 12 months from the date of payment only if: (i) the claim was submitted fraudulently; (ii) the claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim; (iii) the health care services identified in the claim were not delivered by the provider; (iv) the claim payment was for services covered by Title XVIII, Title XIX, or Title XXI of the Social Security Act; (v) the claim payment is the subject of adjustment with another insurer, administrator, or payor; or (vi) the claim payment is the subject of legal action. A company subject to the provisions of this section shall notify a provider of health care services at least 15 days in advance of the imposition of any retroactive denials of previously

paid claims. The provider shall have six months from the date of notification under this paragraph to determine whether the insured as other appropriate insurance, which was in effect of the date of service. Notwithstanding the contractual terms between the company and the provider, the company shall allow for the submission of a claim that was previously denied by another company due to the insured's transfer or termination of coverage.

SECTION 9. Subsection 4(c) of section 108 of chapter 175 of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting, after the word "notice" in line 464, the following words:— , or within 15 days if said notice is submitted electronically,.

SECTION 10. Said subsection 4(c) of said section 108 of said chapter 175, as so appearing, is hereby further amended by inserting, after the word "claim" in line 471, the following words:— , or beginning 15 days after the insurer's receipt of notice of claim if such notice is submitted electronically,.

SECTION 11. Said subsection 4(c) of said section 108 of said chapter 175, as so appearing, is hereby further amended by adding the following paragraph:—

Any appeal of a claimant or provider from the denial of payment or the making of only partial payment hereunder with respect to any claim notice of which is submitted hereunder may be filed within one year of receipt by such claimant or provider of the insurer's notification of denial or partial payment. The commissioner shall report at least annually to the joint committee on health care and the joint committee on insurance on compliance by insurers subject to the provisions of this subsection with the payment provisions of this subsection. For purposes of each such report the commissioner may, by regulation, require the submission of relevant data by insurers.

SECTION 12. Subdivision (G) of section 110 of chapter 175 of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting, after the words "notice" in line 201,

the following words:— , or within 15 days if said notice is submitted electronically,.

SECTION 13. Said subdivision (G) of said section 110 of chapter 175, as so appearing, is hereby further amended by inserting, after the word "claim" in line 208, the following words:— , or beginning 15 days after the insurer's receipt of notice of claim if such notice is submitted electronically,.

SECTION 14. Said subdivision (G) of said section 110 of said chapter 175, as so appearing, is hereby further amended by adding the following paragraph:—

Any appeal of a claimant from the denial of payment or the making of only partial payment hereunder with respect to any claim notice of which is submitted hereunder may be filed within one year of receipt by such claimant of the insurer's notification of denial or partial payment. The commissioner shall report at least annually to the joint committee on health care and the joint committee on insurance on compliance by insurers subject to the provisions of this subsection with the payment provisions of this subsection. For purposes of each such report the commissioner may, by regulation, require the submission of relevant data by insurers.

SECTION 15. Clause (e) of section 8 of chapter 176A of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting, after the word "benefits" in line 33, the following words:— , or within 15 days if said forms are submitted electronically,.

SECTION 16. Said clause (e) of said section 8 of said chapter 176A, as so appearing, is hereby further amended by inserting, after the word "claim" in line 41, the following words:— , or beginning 15 days after the corporation's receipt of notice of claim if such notice is submitted electronically,.

SECTION 17. Said clause (e) of said section 8 of chapter 176A, as so appearing, is hereby further amended by adding the following paragraph:—

Any appeal of any party submitting completed forms for such benefits hereunder from the denial of payment or the making of only partial payment hereunder may be filed within one year of receipt by such party of notification from a nonprofit hospital service corporation of denial or partial payment. The commissioner shall report at least annually to the joint committee on health care and the joint committee on insurance on compliance by nonprofit hospital service corporations subject to the provisions of this subsection with the payment provisions of this subsection. For purposes of each such report the commissioner may, by regulation, require the submission of relevant data by nonprofit hospital service corporations.

SECTION 18. Section 7 of chapter 176B of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting, after the word "services" in line 68, the following words:— , or within 15 days if such claim form is submitted electronically.

SECTION 19. Said section 7 of said chapter 176B, as so appearing, is hereby further amended by inserting, after the word "claim" in line 84, the following words:— , or beginning 15 days after the corporation's receipt of notice of claim if such notice is submitted electronically,.

SECTION 20. Said section 7 of said chapter 176B, as so appearing, is hereby further amended by inserting, after the second paragraph, the following paragraph:—

Any appeal by a participating physician or other provider of health services from the denial of payment or the making of only partial payment hereunder with respect to any completed claim form for covered services that is submitted hereunder may be filed within one year of receipt by such participating physician or other provider of health services of the medical service corporation's notification of denial or partial payment. The commissioner shall report at least annually to the joint committee on health care and the joint committee on insurance on compliance by medical service corporations with the payment provisions of this paragraph. For purposes of each such report the commissioner may, by

regulation, require the submission of relevant data by medical service corporations.

SECTION 21. Chapter 176D of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting after section 3B the following two sections:—

Section 3C. The commissioner shall establish, by regulation, mechanisms for auditing compliance with payment requirements imposed pursuant to sections 108 and 111 of chapter 175, section 8 of chapter 176A, section 7 of chapter 176B, section 6 of chapter 176G, and section 2 of chapter 176I, and for determining, by statistical analysis or otherwise, the extent that an entity subject to any of those provisions exhibits a pattern of late payment to claimants or providers. The commissioner shall take such steps as he determines reasonable and appropriate to correct any pattern of non-compliance by any such entity that he deems improper, including but not limited to requiring such entity to institute payments on account to providers.

Section 3D. In accordance with regulations issued by the commissioner, entities subject to section 3A of this chapter shall implement universal electronic claims processing systems that comply fully with the requirements of the federal health insurance portability and accountability act.

SECTION 22. Section 6 of chapter 176G of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting, after the word "services" in line 15, the following words:— , or within 15 days if such forms are submitted electronically,.

SECTION 23. Said section 6 of said chapter 176G, as so appearing, is hereby further amended by inserting, after the word "reimbursement" in line 25, the following words:— , or beginning 15 days after the insurer's receipt of notice of claim if such notice is submitted electronically,.

SECTION 24. Said section 6 of said chapter 176G, as so appearing, is hereby further amended by adding the following four paragraphs:—

Following a notification by a health maintenance organization to a provider of health care services pursuant to (iii) above, when said provider of health care services has submitted to the health maintenance organization all of the additional information and documentation identified by such organization as needed to complete said forms for reimbursement, said health maintenance organization shall pay or deny the claim, in whole or in part, within 10 business days, and shall give said provider the reasons for any denial. If a health maintenance organization fails to comply with the provisions of the preceding sentence, said health maintenance organization shall pay interest to the provider of health care services as calculated above in this section, which interest shall accrue beginning 10 days following submission by said provider of health care services of such additional information and documentation. A claim shall be considered paid on the date in which a provider receives full payment or a partial payment with an explanation for the unpaid balance.

Any appeal by a participating provider of health care services from the denial of payment or the making of only partial payment hereunder with respect to any completed forms for reimbursement that are submitted hereunder may be filed within one year of receipt by such participating provider of health care services of the health maintenance organization's notification of denial or partial payment.

The commissioner shall report at least annually to the joint committee on health care and the joint committee on insurance on compliance by health maintenance organizations with the payment provisions of this paragraph. For purposes of each such report the commissioner may, by regulation, require the submission of relevant data by health maintenance organizations.

Nothing in this chapter shall prohibit a health maintenance organization and a provider of health care services from entering into a contract that includes claim payment provisions that meet or exceed the claims payment requirements of this section.

SECTION 25. Section 10 of said chapter 176G of the General Laws, as most recently amended by section 41 of chapter 141 of the Acts of 2003, is hereby amended by inserting, after the second paragraph, the following new paragraph:—

The commissioner shall establish uniform reporting requirements and standardized definitions for the reports to be submitted pursuant to the preceding paragraph, so as to permit valid comparative analyses of financial, statistical and other data among health maintenance organizations, including, for example, the comparison of medical loss ratios among the various health maintenance organizations. In establishing such requirements and definitions, the commissioner shall, among other considerations as he shall deem appropriate, give consideration to the information reasonably required by providers of health care services that may take risk under contracts with health maintenance organizations.

SECTION 26. Section 2 of chapter 176I of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting, after the word "provider" in line 40, the following words:— , or within 15 days if such completed forms for reimbursement are submitted electronically.

SECTION 27. Said section 2 of said chapter 176I, as so appearing, is hereby further amended by inserting, after the word "reimbursement" in line 49, the following words:— , or beginning 15 days after the organization's receipt of request for reimbursement if such notice is submitted electronically.

SECTION 28. Said section 2 of said chapter 176I, as so appearing, is hereby further amended by adding the following four paragraphs:—

Following a notification by an organization to a health care provider pursuant to (iii) above, when said health care provider has submitted to the organization all of the additional information and documentation identified by such organization as needed to complete said forms for reimbursement, said organization shall pay or deny the claim, in whole or in part, within 10 business days, and shall give said provider the reasons for any denial. If an organization fails to comply with the provisions of the preceding sentence, said organization shall pay interest to the health care provider as calculated above in this section, which interest shall accrue beginning 10 days following submission by said health care provider of the additional information and documentation. A

claim shall be considered paid on the date in which a provider receives full payment or a partial payment with an explanation for the unpaid balance.

Any appeal by a health care provider from the denial of payment or the making of only partial payment hereunder with respect to any completed forms for reimbursement that are submitted hereunder may be filed within one year of receipt by such health care provider of the organization's notification of denial or partial payment.

The commissioner shall report at least annually to the joint committee on health care and the joint committee on insurance on compliance by organizations subject to this chapter with the payment provisions of this paragraph. For purposes of each such report the commissioner may, by regulation, require the submission of relevant data by such organizations.

Nothing in this chapter shall prohibit an organization and a health care provider from entering into a contract that includes claim payment provisions that meet or exceed the claims payment requirements of this section.

SECTION 29. The commissioner of insurance shall establish the uniform reporting requirements and standardized definitions required by the second paragraph of section 30 of chapter 176G of the General Laws, as added by section 22 of this act, by no later than July 1, 2005.

SECTION 30. This act shall take effect upon its passage.